EDMUND G. BROWN JR., Attorney General
of the State of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General
KAREN L. GORDON, State Bar No. 137969
Deputy Attorney General
110 West "A" Street, Suite 1100
San Diego, CA 92101

P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2073
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 2008-66
JASON C. CARLSON, aka **JASON CURTIS CARLSON** 960 N Tustin Street, #383 Orange, CA 92867	OAH No. L2007110443 **DEFAULT DECISION AND ORDER**
Registered Nurse License No. 590421, Respondent.	[Gov. Code, §11520]

FINDINGS OF FACT

1. On or about August 16, 2007, Complainant Ruth Ann Terry, M.P.H., R.N., in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2008-66 against Jason C. Carlson (Respondent) before the Board of Registered Nursing.

2. On or about October 29, 2001, the Board of Registered Nursing (Board) issued Registered Nurse License No. 590421 to Respondent. The license was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2009, unless renewed.

3. On or about August 31, 2007, Sandra Sotelo, an employee of the Department of Justice, served by Certified and First Class Mail a copy of the Accusation No.

2008-66, Statement to Respondent, Notice of Defense, Request for Discovery, and Government Code sections 11507.5, 11507.6, and 11507.7 to Respondent's address of record with the Board, which was and is: 960 N. Tustin Street, #383, Orange, CA 92867. A copy of the Accusation is attached as Exhibit A, and is incorporated herein by reference.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c).

5. On or about September 20, 2007, Respondent signed and returned a Notice of Defense, requesting a hearing in this matter. Respondent indicated on his Notice of Defense that he was represented by Attorney Samuel Spital in this case. A Notice of Hearing was served by mail to Respondent's Attorney Samuel Spital and it informed him that an administrative hearing in this matter was scheduled for June 9, 2008. Complainant's counsel confirmed with Attorney Samuel Spital that Respondent received the Notice of Hearing and knew that the hearing was scheduled to begin on June 9, 2008. Attorney Spital advised that he was not representing Respondent at the hearing. Respondent failed to appear at the hearing.

6. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

7. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

8. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the evidence on file herein, finds that the allegations in Accusation No. 2008-66 are true.

9. The total cost for investigation and enforcement in connection with the Accusation are $12,645.25 as of June 9, 2008.

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DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Jason C. Carlson has subjected his Registered Nursing License No. 590421 to discipline.

2. A copy of the Accusation is attached.

3. The agency has jurisdiction to adjudicate this case by default.

4. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation:

a. Respondent's license is subject to discipline for unprofessional conduct under Code section 2762, subdivision (e), in that Respondent made false, grossly incorrect, or grossly inconsistent entries in hospital, patient, or other records pertaining to controlled substances and/or dangerous drugs regarding 27 patients at Scripps Memorial Hospital and ten patients at UCSD Medical Center.

b. Respondent's license is subject to discipline for unprofessional conduct under Code section 2762, subdivision (a), in that while working at Scripps Memorial Hospital and the University of California San Diego Medical Center, Respondent obtained controlled substances and/or dangerous drugs by fraud, deceit, misrepresentation, or subterfuge, or by the concealment of material facts, in violation of Health and Safety Code section 11173, subdivision (a).

c. Respondent's license is subject to discipline for unprofessional conduct under Code section 2762, subdivision (a), in that while working at Scripps Memorial Hospital and the University of California San Diego Medical Center, Respondent possessed controlled substances and/or dangerous drugs without a valid prescription therefor, in violation of Code section 4060.

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ORDER

IT IS SO ORDERED that Registered Nurse License No. 590421, heretofore issued to Respondent Jason C. Carlson, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on October 5, 2008.

It is so ORDERED September 5, 2008

La Francine W Tate

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

Carlson.Default.wpd
DOJ docket number:SD2006801257

Attachment:

Exhibit A: Accusation No.2008-66

Exhibit A

Accusation No. 2008-66

EDMUND G. BROWN JR., Attorney General
of the State of California
LINDA K. SCHNEIDER
Supervising Deputy Attorney General
KAREN L. GORDON, State Bar No. 137969
Deputy Attorney General
California Department of Justice
110 West "A" Street, Suite 1100
San Diego, CA 92101

P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-2064
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	Case No. 2008-64
JASON C. CARLSON, aka **JASON CURTIS CARLSON** 960 N Tustin Street, #383 Orange, CA 92867 **Registered Nurse License No. 590421,** Respondent.	**ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. **Jason C. Carlson**. On or about October 29, 2001, the Board of Registered Nursing ("Board") issued Registered Nurse License Number 590421 ("license") to Jason C. Carlson, also known as Jason Curtis Carlson ("Respondent"). The license will expire on January 31, 2009, unless renewed.

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JURISDICTION

3. Section 2750 of the Business and Professions Code ("Code") provides:

> Every certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article [Article 3 of the Nursing Practice Act (Bus. & Prof. Code, § 2700 et seq.)]. As used in this article, 'license' includes certificate, registration, or any other authorization to engage in practice regulated by this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code [the Administrative Procedure Act], and the board shall have all the powers granted therein.

STATUTORY PROVISIONS

4. Code section 2761 provides, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

5. Code section 2762 provides, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
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> . . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

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6. Code section 4022 provides:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

7. Code section 4060 provides:

No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse- midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer.

8. Health and Safety Code section 11173, subdivision (a), provides:

(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

9. Code section 125.3 provides that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

REGULATORY PROVISIONS

10. California Code of Regulations, title 16, section 1442, provides:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

DRUGS

11. "Ativan," a brand name for Lorazepam, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug within the meaning of Code section 4022.

12. "Demerol," a brand name for Meperidine, is a Schedule II controlled substance pursuant to Health and Safety Code section 1105, subdivision (b)(2), and a dangerous drug within the meaning of Code section 4022.

13. "Dilaudid," a brand name for Hydromorphone, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(k), and a dangerous drug pursuant to Code section 4022.

14. "Methadone" is a Schedule II controlled substance, and a dangerous drug within the meaning of Code section 4022.

15. "Morphine/Morphine Sulfate" is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(m), and a dangerous drug within the meaning of Code section 4022.

16. "Valium," a brand name for Diazepam, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug within the meaning of Code section 4022.

17. "Vicodin," a brand name for Dihydrocodeinone, is a Scheduled III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug within the meaning of Code section 4022.

Background

18. Scripps Memorial Hospital. Respondent worked at Scripps Memorial Hospital (Scripps), located in La Jolla, California, from on or about November 12, 2004, until on or about December 8, 2004. An audit of Respondent's controlled substance transactions and Scripps' patient medical records revealed that during November and December 2004, Respondent obtained multiple quantities of controlled substances in contravention of physician orders and without physician orders. Respondent also obtained controlled substances for administration for patients who were not present at Scripps at the time those substances were obtained.

19. University of California San Diego Medical Center. On or about March 23, 2005, the Board received a complaint from Linda Levy, the Director of Patient Care Services for University of California San Diego Medical Center (UCSD), located in San Diego, California, alleging that Respondent had committed multiple discrepancies in his transaction records pertaining to controlled substances. UCSD's review of Respondent's controlled substance transaction records revealed that while working at UCSD from on or about December 21, 2004, until on or about March 22, 2005, Respondent obtained and possessed controlled substances in contravention of physician orders and without physician orders to do so.

FIRST CAUSE FOR DISCIPLINE

(False, Grossly Incorrect, or Grossly Inconsistent Record Entries Pertaining to Controlled Substances and/or Dangerous Drugs)

20. Respondent's license is subject to discipline for unprofessional conduct under Code section 2762, subdivision (e), in that Respondent made false, grossly incorrect, or grossly inconsistent entries in hospital, patient, or other records pertaining to controlled substances and/or dangerous drugs, as follows:

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a. **Scripps Memorial Hospital**.

1) **Patient #2**. On or about November 29, 2004, at approximately 2244 hours, without a physician's order to do so, Respondent obtained two Vicodin tablets for administration to Patient #2. Respondent failed to account for the two Vicodin tablets in any hospital, patient, or other record.

2) **Patient #6**. On or about December 2, 2004, at approximately 1130 hours, without a physician's order to do so, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #6. Respondent failed to account for the 2 mg dose of Dilaudid in any hospital, patient, or other record.

3) **Patient #7**. On or about December 8, 2004, at approximately 1148 hours, without a physician's order to do so, Respondent obtained a 100 mg dose of Demerol (Meperidine) for administration to Patient #7. Respondent recorded that the 100 mg dose of Demerol (Meperidine) had been wasted.

4) **Patient #13**. On or about December 8, 2004, at approximately 1602 hours, without a physician's order to do so, Respondent obtained a 100 mg dose of Demerol (Meperidine) for administration to Patient #13. Respondent recorded that the 100 mg dose of Demerol (Meperidine) had been wasted.

5) **Patient #17**. On or about December 8, 2004, at approximately 0806 hours, without a physician's order to do so, Respondent obtained a 100 mg dose of Demerol (Meperidine) for administration to Patient #17. Respondent record that the 100 mg dose of Demerol (Meperidine) had been wasted.

6) **Patient #22**. On or about December 6, 2004, at approximately 1334 hours, without a physician's order to do so, Respondent obtained a 100 mg dose of Demerol (Meperidine) for administration to Patient #22. Respondent recorded that the 100 mg dose of Demerol (Meperidine) had been wasted.

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7) **Patient #27**. On or about November 25, 2004, at approximately 1620 hours, without a physician's order to do so, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #27. Respondent failed to account for 2 mgs of the Dilaudid in any hospital, patient, or other record.

8) **Patient #28**. On or about November 25, 2004, at approximately 1219 hours, without a physician's order to do so, Respondent obtained a 100 mg dose of Demerol (Meperidine) for administration to Patient #28. Respondent recorded that the 100 mg dose of Demerol (Meperidine) had been wasted.

9) **Patient #30**. On or about November 29, 2004, between approximately 2113 hours and 2158 hours, Respondent obtained a total dosage of 6 mgs of Dilaudid for administration to Patient #30. Respondent recorded that 4 mgs of the Dilaudid had been administered, but Respondent failed to account for 2 mgs of the Dilaudid in any hospital, patient, or other record.

10) **Patient #32**. On or about December 2, 2004, at approximately 1125 hours, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #32. Respondent recorded the wastage of 1 mg of the Dialaudid, but Respondent failed to account for 1 mg of the Dilaudid in any hospital, patient, or other record.

11) **Patient #34**. On or about November 30, 2004, at approximately 1814 hours, without a physician's order to do so, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #34. At approximately 1928 hours, without a physician's order to do so, Respondent obtained another 2 mg dose of Dilaudid for administration to Patient #34. Respondent recorded the administration of 1 mg of the Dilaudid, but failed to account for 3 mgs of the Dilaudid in any hospital, patient, or other record.

12) **Patient #36**. On or about November 30, 2004, at approximately 1326 hours, without a physician's order to do so, Respondent obtained a 100 mg dose of Demerol (Meperidine) for administration to Patient #36. Respondent failed to account for the 100 mg dose of Demerol (Meperidine)in any hospital, patient, or other record.

13) **Patient #37**. On or about November 22, 2004, between approximately 0912 hours and 1715 hours, Respondent obtained a total dosage of 30 mgs of Morphine Sulfate for administration to Patient #37. At approximately 1041 hours, without a physician's order to do so, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #37. Respondent recorded the administration of 10 mgs and the wastage of 15mgs of the Morphine Sulfate, and the wastage of 1.5 mgs of the Dilaudid. Respondent failed to account for 5 mgs of the Morphine Sulfate, and 2 mgs of the Dilaudid in any hospital, patient, or other record.

14) **Patient #38**. On or about November 15, 2004, at approximately 1029 hours, without a physician's order to do so, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #38. Respondent failed to account for the 2 mg dose of Dilaudid in any hospital, patient, or other record.

15) **Patient #39**. On or about November 13, 2004, at approximately 1322 hours, Respondent obtained a 5 mg dose of Morphine Sulfate for administration to Patient #39. Respondent inconsistently recorded in a hospital, patient, or other record that he had administered a total dosage of 7.5 mgs of Morphine Sulfate to Patient #39.

16) **Patient #40**. On or about November 25, 2004, at 0851 hours, Respondent obtained a 2 mg dose of Morphine Sulfate for administration to Patient #40. At approximately 0927 hours, Respondent obtained a 5 mg dose of Morphine Sulfate for administration to Patient #40. At approximately 1037 hours, without a physician's order to do so, Respondent obtained a 100 mg dose of Demerol (Meperidine) for administration to Patient #40. Respondent recorded the administration of 4 mgs of the Morphine Sulfate, but failed to account for 3 mgs of the Morphine Sulfate and the 100 mg dose of Demerol (Meperidine) in any hospital, patient, or other record.

17) **Patient #41**. On or about December 2, 2004, at approximately 1323 hours, 1351 hours, and 1429 hours, Respondent obtained a 2 mg dose of Dilaudid each time for administration to Patient #41. Respondent recorded the administration of 2 mgs and the

wastage of 3 mgs of the Dilaudid, but failed to account for 1 mg of the Dilaudid in any hospital, patient, or other record.

18) **Patient #42**. On or about November 12, 2004, at approximately 0925 hours, Respondent obtained a 2 mg dose of Ativan for administration to Patient #42. Respondent recorded the administration of 0.5 mgs of the Ativan, but failed to account for 1.5 mgs of the Ativan in any hospital, patient, or other record.

19) **Patient #45**. On or about November 29, 2004, at approximately 1137 hours, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #45. At approximate 1247 hours, Respondent obtained a 10 mg dose of Diazepam (Valium) for administration to Patient #45. At approximately 1248 hours, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #45. Respondent recorded the administration of 0.5 mgs and the wastage of 3 mgs of the Dilaudid, and the wastage of 7 mgs of the Valium. Respondent failed to account for 2.5 mgs of the Dilaudid, and 3 mgs of the Valium in any hospital, patient, or other record.

20) **Patient #55**. On or about November 13, 2004, at approximately 0755 hours, Respondent obtained a 75 mg dose of Demerol for administration to Patient #55. And, at approximately 1109 hours, Respondent obtained a 100 mg dose of Demerol for administration to Patient #55. Respondent recorded the administration of 100 mgs of the Demerol, but failed to account for 75 mgs of the Demerol in any hospital, patient, or other record.

21) **Patient #57**. On or about November 24, 2004, at approximately 0855 hours, without a physician's order to do so, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #57. Respondent recorded the wastage of 1.5 mgs of Dilaudid at approximately 0855 hours. Respondent failed to account for 0.5 mgs of the Dilaudid in any hospital, patient, or other record.

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22) **Patient #58**. On or about November 24, 2004, at approximately 1400 hours, without a physician's order to do so, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #58. Respondent failed to account for the 2 mg dose of Dilaudid in any hospital, patient, or other record.

23) **Patient #63**. On or about November 13, 2004, at approximately 1534 hours, 1542 hours, 1658 hours, and 1719 hours, without a physician's order to do so, Respondent obtained a 2 mg dose of Dilaudid each for administration to Patient #63. Respondent recorded the wastage of 1.75 mgs of the Dilaudid, but failed to account for 6.25 mgs of the Dilaudid in any hospital, patient, or other record.

24) **Patient #65**. On or about December 6, 2004, at approximately 1118 hours, without a physician's order to do so, Respondent obtained a 100 mg dose of Demerol for administration to Patient #65. Respondent failed to account for the 100 mg dose of Demerol in any hospital, patient, or other record.

25) **Patient #69**. On or about December 2, 2004, at approximately 1133 hours, without a physician's order to do so, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #69. Patient #69 was not in the hospital on that day. Respondent recorded that the 2 mg dose of Dilaudid had been wasted.

26) **Patient #70**. On or about December 2, 2004, at approximately 2129 hours, without a physician's order to do so, Respondent obtained two Vicodin tablets for administration to Patient #70. Patient #70 was not in the hospital on that day. Respondent failed to account for the two Vicodin tablets in any hospital, patient, or other record.

27) **Patient #72** On or about November 29, 2004, at approximately 1000 hours, without a physician's order to do so, Respondent obtained a 100 mg dose of Demerol from the emergency room for administration to Patient #72. Patient #72 was not in the emergency room on that day. Respondent failed to account for the 100 mg dose of Demerol in any hospital, patient, or other record.

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b. **University of California San Diego Medical Center**.

1) **Patient #1**. On or about March 3, 2005, at approximately 1245 hours, without a physician's order to do so, Respondent obtained a 150 mg dose of Demerol for administration to Patient #1. Respondent recorded that the 150 mg dose of Demerol had been wasted.

2) **Patient #2**. On or about March 9, 2005, at approximately 1506 hours, without a physician's order to do so, Respondent obtained a 100 mg dose of Demerol for administration to Patient #2. Respondent failed to account for the 100 mg dose of Demerol in any hospital, patient, or other record.

3) **Patient #3**. On or about March 18, 2005, at approximately 1131 hours, without a physician's order to do so, Respondent obtained a 150 mg dose of Demerol for administration to Patient #3. Respondent recorded that the 150 mg dose of Demerol had been wasted.

4) **Patient #4**. On or about March 18, 2005, at approximately 1225 hours, without a physician's order to do so. Respondent obtained a 100 mg dose of Demerol for administration to Patient #4. Respondent recorded that the 100 mg dose of Demerol had been wasted.

5) **Patient #7**. On or about March 2, 2005, at approximately 1055 hours, in contravention of physician orders, Respondent obtained three each 50 mg doses of Demerol for administration to Patient #7. Respondent recorded the administration of 50 mgs of the Demerol to Patient #7 and that 100 mgs of the Demerol had been wasted.

6) **Patient #8**. On or about March 21, 2005, at approximately 1438 hours and 1441 hours Respondent obtained a 2 mg dose of Dilaudid each time for administration to Patient #8. Respondent recorded the administration of 1 mg of the Dilaudid, but failed to account for 3 mgs of the Dilaudid in any hospital, patient, or other record.

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7) **Patient #10**. On or about March 4, 2005, at approximately 1149 hours, 1242 hours, and 1516 hours, Respondent obtained a 2 mg dose of Dilaudid for administration to Patient #10. Respondent recorded the administration of 1 mgs but failed to account for 5 mgs of the Dilaudid in any hospital, patient, or other record.

8) **Patient #11**. On or about March 9, 2005, without a physician's order to do so, Respondent obtained a 4 mg dose of Dilaudid for administration to Patient #11. Respondent failed to account for the 4 mg dose of Dilaudid in any hospital, patient, or other record.

9) **Patient #12**. On or about March 19, 2005, at approximately 1537 hours, without a physician's order to do so, Respondent obtained three 10 mg doses of Methadone for administration to Patient #12. Respondent failed to account for the 30 mg doses of Methadone in any hospital, patient, or other record.

10) **Patient #16** On or about March 19, 2005, at approximately 1015 hours, without a physician's order to do so, Respondent obtained three 10 mg doses of Methadone for administration to Patient #16. Over five hours later at 1532 hours, the 30 mg of Methadone is shown as wasted.

SECOND CAUSE FOR DISCIPLINE

(Wrongfully Obtaining and Possessing Controlled Substances and/or Dangerous Drugs)

28. Respondent's license is subject to discipline for unprofessional conduct under Code section 2762, subdivision (a), in that while working at Scripps Memorial Hospital and the University of California San Diego Medical Center, Respondent did the following:

a. **Wrongfully Obtaining Controlled Substances and/or Dangerous Drugs**. As set forth under paragraphs 20(a) and 20(b) above, on multiple occasions, Respondent obtained controlled substances and/or dangerous drugs by fraud, deceit, misrepresentation, or subterfuge, or by the concealment of material facts, in violation of Health and Safety Code section 11173, subdivision (a).

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b. **Wrongfully Possessing Controlled Substances and/or Dangerous Drugs.** As set forth under paragraphs 20(a) and 20(b) above, on multiple occasions, Respondent possessed controlled substances and/or dangerous drugs without a valid prescription therefor, in violation of Code section 4060.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

29. Respondent's license is subject to discipline for unprofessional conduct, under Code section 2761, subdivision (a)(1), for the commission of acts of gross negligence while working at Scripps Memorial Hospital and the University of California San Diego Medical Center, as more particularly set forth under paragraphs 20(a) and 20(b), above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 590421, issued to Jason C. Carlson, also known as Jason Curtis Carlson;

2. Ordering Jason C. Carlson, also known as Jason Curtis Carlson, to pay the reasonable costs incurred by the Board in the investigation and enforcement of this case pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 5/16/07

Cliff Hochberg for
RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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